recalculation of reimbursement rates and does not create an independent right to recovery of litigation costs and fees.

IV. Standards

A. In accordance with Section 120, Florida Statutes, Administrative Procedures Act, this plan shall be made available for public inspection, and a public hearing, if requested, shall also be held so that interested members of the public shall be afforded the opportunity to review and comment on the plan.

B. For purposes of establishing reimbursement ceilings, each nursing home within the State shall be classified into one of six reimbursement classes as defined in V. A.3 of this plan. Separate reimbursement ceilings shall be established for each class. Separate operating and patient care reimbursement ceilings shall be established for each class, but the property cost component shall be subject to a statewide reimbursement ceiling for facilities still being reimbursed depreciation and interest per Section III.G. 3.-5.

C. The ceilings shall be determined prospectively and shall be effective semiannually, on January 1 and July 1. The most current cost reports postmarked or accepted by a common carrier by September 30 and March 31 and received by October 15 and April 15, respectively, shall be used to establish the operating and patient care class ceilings. Beginning with the January 1, 1988, rate period additional ceilings based on the Target Rate System shall also be imposed. Beginning with the July 1, 1991 rate period, additional ceilings for new providers shall also be imposed. The first cost report submissions for all newly-constructed facilities shall be used to establish the property cost ceiling. The first cost report year-end of these newly-constructed facilities shall be after October 1, 1977. In addition, all facilities with year ends prior to that of the one hundredth facility in

an array from most current to least current year end shall not be considered in setting the property cost ceilings. Ceilings shall be set at a level which the State determines to be adequate to reimburse the allowable and reasonable costs of an economically and efficiently operated facility. The property ceiling for facilities being reimbursed per Section III.G.3.-5. of this plan pending transition to payments based on the FRVS shall be the ceiling in effect at July 1, 1985. The operating and patient care class ceilings shall be the maximum amount paid to any provider in that class as reimbursement for operating and patient care costs. Establishment of prospective class ceilings and an individual provider's reimbursement rate will reasonably take into account economic conditions and trends during the time periods covered by the payment rates. A provider shall be exempt from the operating and patient care class ceilings and target rate ceilings if all of the following criteria are satisfied:

a) All of the resident population are dually diagnosed with medical and psychiatric conditions.

b) No less than 90 percent of the resident population suffer from at least one of the following: severe behavioral, emotional, or cognitive difficulties resulting from their psychiatric impairment.

c) The facility provides clinically appropriate care to address these behavioral, cognitive, and emotional deficits.

d) A medically approved individual treatment plan is developed and implemented for each patient. The plan comprehensively addresses the client's medical, psychiatric, and psychosocial needs.

e) The facility complies with the licensure provisions for specialty psychiatric hospitals in accordance with Rule 59A-3 FAC.

f) The facility complies with HRSR 95-3 with regard to psychotropic drugs

or establish written facility standards which meet or exceed this regulation.

g) The facility complies with HRSM 180-1 with regard to quality assurance procedures or establishes written facility standards which meet or exceed this regulation.

Beginning on or after January 1, 1984, provider whose reimbursement rates are limited to the class ceiling for operating and patient care costs shall have their reimbursement exceeded under the circumstances described below. The provider must demonstrate to the Agency that unique medical care requirements exist which require extraordinary outlays of funds causing the provider to exceed the class ceilings. Circumstances which shall require such an outlay of funds causing a provider to exceed the class ceilings as referenced above shall be limited to:

a) Acquired Immune Deficiency Syndrome (AIDS) diagnosed patients requiring isolation care;

b) Medically fragile patients under age 21 who require skilled nursing care.

The period of reimbursement in excess of the class ceilings shall not exceed 6 months. A flat rate shall be paid for the specific patients identified, in addition to the average per diem paid to the facility. The flat rate amount for AIDS patients shall include the costs of incremental staffing and isolation supplies, and shall be trended forward each rate semester using the DRI indices used to compute the operating and patient care ceilings. The flat rate payment for Medically fragile patients under age 21 who require skilled nursing care shall be the same as the flat rate payment for "grandfathered in" ventilator patients, and shall be trended forward using the DRI indices in the same manner as the payment for AIDS patients. Patients requiring the use of a ventilator and related equipment whose costs were approved under the 10/1/85 reimbursement plan shall be

"grandfathered in"--that is, a flat rate shall be paid for incremental staffing costs only. Costs of the ventilator and related equipment, that is, rent, depreciation, interest, insurance and property taxes, shall be paid in addition to the flat rate. No new ventilator patients shall be approved for payment above the ceilings as of the effective date of this plan. Ventilator patients that have their Medicaid eligibility canceled and later reinstated will no longer be "grandfathered in." Instead, they are considered to be new ventilator patients. These incremental costs shall be included in the cost reports submitted to AHCA, but shall not be included in the calculation of future prospective rates. The incremental costs of staffing and isolation supplies for AIDS patients, incremental costs of staffing for ventilator patients, and the cost of Medically fragile patients under age 21 who require skilled nursing care, shall be adjusted out based upon the flat rate payments made to the facility, in lieu of separately identifying actual costs. The cost of ventilators and related equipment shall be adjusted out based upon payments made to the facility, in lieu of separately identifying actual costs. Special billing procedures shall be obtained by the provider from the Medicaid Office of Program Development. The class ceilings may also be exceeded in cases where Medicaid patients are placed by the Agency for Health Care Administration in hospitals or in non-Medicaid participating institutions on a temporary basis pending relocation to participating nursing homes, for example, upon closure of a participating nursing home. The HCFA Regional Office shall be notified in writing at least 10 days in advance in all situations to which this exception is to be applied, and shall be advised of the rationale for the decision, the financial impact, including the proposed rates, and the number of facilities and patients involved. AHCA shall extend the class ceiling exception for subsequent 6-month periods upon making a determination that a need for the exception still exists and upon providing the HCFA Regional Office with another advance written notification as stated above.

D. Effective October 1, 1985, FRVS shall be used to reimburse facilities for property. To prevent any facility from receiving lower reimbursement under FRVS than under the former method where depreciation plus interest costs were used to calculate payments, there shall be a transition period in which some facilities shall continue to be paid depreciation plus interest until such time as FRVS payments exceed depreciation and interest payments as specified in Section V.E.1.h. At that time, a facility shall begin reimbursement under the FRVS. Facilities entering the program after October 1, 1985 that had entered into an armslength (not between related parties) legally enforceable agreement for construction or purchase loans prior to October 1, 1985 shall be eligible for the hold harmless clause per Section V.E.l.h.

E. The prospectively-determined individual nursing home's rate will be adjusted retroactively to the effective date of the affected rate under the following circumstances:

1. An error was made by AHCA in the calculation of the provider's rate.
2. A provider submits an amended cost report used to determine the rate in effect. An adjustment due to the submission of an amended cost report shall not be granted unless the amended cost report shall cause a change of 1 or more percent in the total reimbursement rate. The provider shall submit documentation supporting that the 1 percent requirement is satisfied. This documentation shall include a rate calculation using the same methodology and in a similar format as used by the Agency in calculating rates. The amended cost report shall be filed by the filing date of the subsequent cost report or the date of the first field audit exit conference for the period being amended or the date a desk audit letter is received by the provider for the period being amended, whichever is earlier.

3. Further desk or on-site audits of cost reports disclose a change in allowable costs in those reports.

4. The section shall not apply to the case-mix adjustment calculated in Section V.G. of this plan.

F. The Medicaid program shall pay a single level of payment rate for all levels of nursing care. This single per diem shall be based upon each provider's allowable Medicaid costs divided by the Medicaid patient days from the most recent cost report subject to the rate setting methodology in Section V. of this plan.

G. Reimbursement of operating and patient care costs are subject to class ceilings. Property costs are subject to statewide ceilings, which shall be the ceilings computed at July 1, 1985, for facilities being reimbursed under Section III.G.3.-5. of this plan. For facilities being reimbursed under FRVS, the cost per bed ceiling shall be per Section V.E.1.g. of this plan. Return on equity and use allowance are passed through and are not subject to a ceiling.

H. An incentive factor is available to providers whose operating per diems are under the class ceiling and who have provided quality of care resulting in standard ratings on the license issued by AHCA pursuant to the provisions of Rule 59A-4.128, F.A.C. Additional incentive is available for providers who have been granted superior quality of care licensure ratings. Beginning with the July 1, 1996, rate semester, incentive factor payments will no longer be made and a Medicaid Adjustment Rate shall be made pursuant to Section V.F. of this plan.

I. A low occupancy adjustment factor shall be applied to costs of certain providers.

J. The following provisions apply to interim changes in component reimbursement rates, other than through the routine semi-annual rate setting process.

1. Requests for rate adjustments to account for increases in property-related costs due to capital additions, expansions, replacements, or repairs, or for allowable lease cost increases shall not be considered in the interim

between cost report submissions, except for the addition of new beds or if the cost of the specified expansion, addition, replacement, allowable lease cost increase or repair would cause a change of 1 percent or more in the provider's total per diem reimbursement rate. For facilities being reimbursed under FRVS, property-related costs shall not be considered in any interim rate request. Adjustments to FRVS rates for property-related costs shall be made only on January 1 and July 1 of each year per Section V.E.1.j.

2. Interim rate changes reflecting increased costs occurring as a result of patient care or operating changes shall be considered only if such changes were made to comply with existing State or Federal rules, laws, or standards, and if the change in cost to the provider is at least $5000 and would cause a change of 1 percent or more in the provider's current total per diem rate.

(a) If new State or Federal laws, rules, regulations, licensure and certification requirements, or new interpretations of existing laws, rules, regulations, or licensure and certification requirements require providers to make changes that result in increased or decreased patient care, operating, or capital costs, requests for component interim rates shall be considered for each provider based on the budget submitted by the provider. All providers' budgets submitted shall be reviewed by the Agency and shall be the basis for establishing reasonable cost parameters.

(b) In cases where new State or Federal requirements are imposed that affect all providers, appropriate adjustments shall be made to the class ceilings to account for changes in costs caused by the new

requirements effective as of the date of the new requirements or implementation of the new requirements, whichever is later.

3. Interim rate requests resulting from 1., and 2. above must be submitted within 60 days after the costs are incurred, and shall be accompanied by a 12-month budget which reflects changes in services and costs. For providers being reimbursed under FRVS, interim rate adjustments due to capital additions or improvements shall be made per Section V.E.1.j. An interim reimbursement rate, if approved, shall be established for estimated additional costs retroactive to the time of the change in services or the time the costs are incurred, but not to exceed 60 days before the date AHCA receives the interim rate request. The interim per diem rate shall reflect only the estimated additional costs, and the total reimbursement rate paid to the provider shall be the sum of the previously established prospective rates plus the interim rate. A discontinued service would offset the appropriate components of the prospective per diem rates currently in effect for the provider. Upon receipt of a valid interim rate received after August 31, 1984, the AHCA Office of Medicaid shall determine whether additional information is needed from the provider and request such information within 30 days. Upon receipt of the complete, legible additional information as requested, the AHCA Office of Medicaid shall approve or disapprove the interim rate request within 60 days. If the AHCA office of Medicaid does not make such determination within the 60 days, the interim rate request shall be deemed approved.

4. Interim Rate Settlement. Overpayment as a result of the difference between the approved budgeted interim rate and actual costs of the budgeted item shall be refunded to AHCA. Underpayment as a result of

the difference between the budgeted interim rate and actual costs shall be paid to the provider.

5. Interim rates shall not be granted for fiscal periods that have ended.

K. The following applies to rate periods prior to July 1, 1985: In the event that a provider receives a new licensure rating making him eligible or ineligible for any amount of incentive payments, his prospective reimbursement rate shall be changed to reflect his new licensure rating and shall be effective beginning on the first day of the month after the month in which the new licensure rating became effective. For rates effective on or after July 1, 1985, the incentive payments based on licensure ratings shall be calculated according to the provisions of Section V.D. below.

L. Effective April 1, 1999 there will be a case-mix adjustment, which will be paid as an add-on to the patient care component of the provider's total reimbursement rate. The amount of the case-mix adjustment will be calculated pursuant to Section V.G. of this plan.

M. Aggregate Test Comparing Medicaid to Medicare 42 CFR 447.253(b)(2) (1994) provides that states must assure the Health Care Financing Administration that "(t)he Medicaid agency's estimated average proposed payment rate...pay no more in the aggregate for...long-term care facility services than the amount that...would be paid for the services under the Medicare principles of reimbursement." At any rate-setting period, if the aggregate reimbursement to be paid is higher than would be paid under Medicare reimbursement principles, the following steps shall be taken for that rate semester, in order, as necessary to meet the aggregate test:

1. The increase in property reimbursement due to indexing for FRVS shall be reduced until the upper limit test is met for that rate semester. The amount of the property reimbursement rate paid under FRVS shall be reduced, but

not below the initial per diem the provider received under FRVS. This per diem is inclusive of all components of FRVS, including property, return on equity, taxes and insurance.

2. Any incentive payments or other payments that exceed the projected cost rate shall be reduced on a pro rata basis until Medicaid aggregate payments are equal to or less than the amount that would be paid for services under the Medicare reimbursement principles.

3. If provisions 1 and 2 are implemented in order to meet the upper limit test, for a period of 1 year, this plan shall be reanalyzed and formally amended to conform to the necessary program cost limits.

N. Payments made under this plan are subject to retroactive adjustment if approval of this plan or any part of this plan is not received from the federal Health Care Financing Administration (HCFA). The retroactive adjustments made shall reflect only the federal financial participation portions of payments due to elements of this plan not authorized by HCFA.

V. Method

This section defines the methodologies to be used by the Florida Medicaid program in establishing reimbursement ceilings and individual nursing home reimbursement rates.

A. Ceilings.

1. Ceilings shall be determined prospectively and shall be effective semi-annually on January 1 and July 1. The most current acceptable cost reports postmarked or accepted by a common carrier by September 30 or March 31 and received by October 15 or April 15, respectively, of each year and the provider's most recent reimbursement rates shall be used to establish the operating and patient care ceilings. More current cost reports shall be used to establish rates if production time permits. The first cost report submissions for all newly-constructed facilities shall be used to establish